STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to keep a resident informed and did not ensure a resident exercised his right to choose for one out of eight sampled residents (Resident 74) by failing to: 1. Ensure licensed nursing staff informed Resident 74 of the medications being administered prior to administration. 2. Ensure Resident 74 was given an opportunity to participate during medication administration. These deficient practices violated Resident 74's rights. Findings: During a review of Resident 74's Admission Record, the admission record indicated Resident 74 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF, a chronic condition in which the heart does not pump blood adequately) and chronic kidney disease (CKD, a gradual loss of kidney function). During a review of Resident 74's History and Physical (H&P) dated 2/10/2024, the H&P indicated Resident 74 had fluctuating capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/12/2024, the MDS indicated that Resident 74's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 74 usually made himself understood and usually had the ability to understand others. The MDS indicated Resident 74 required partial/ moderate assistance (helper does less than half the effort) for oral hygiene, personal hygiene, lower body dressing and putting on/taking off footwear. During an observation on 4/2/2024 at 9:09 a.m. in Resident 74's room, Licensed Vocational Nurse (LVN) 4 was observed giving Resident 74 a medicine cup containing pills. LVN 4 handed the medication to Resident 74 without explaining what medications were in the cup. Resident 74 then swallowed the pills. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2024 at 9:13 a.m. with Resident 74, in Resident 74's room, Resident 74 stated he did not know what medication he just swallowed. Resident 74 stated LVN 4 did not explain to him what medication was given to him. Resident 74 stated it would have been nice to know what he swallowed before he swallowed it. During an interview on 4/2/2024 at 9: 18 a.m. with LVN 4, in Resident 74's room, LVN 4 stated it was the facility's policy and she was taught to inform the residents what medications were being administered. LVN 4 stated she was supposed to inform Resident 74 of the type of medications that were administered because it was the resident's right to know and she did not do that. LVN 4 stated not informing residents about the medication they took was a violation of their right to be informed. During an interview on 4/3/2024 at 3:31 p.m. with the Director of Staff Development (DSD), the DSD stated all licensed nurses must explain to the residents what medications they were administering and what the medication was for. The DSD stated residents must be explained about their medications because it was their right to be informed of the medications they were taking. The DSD stated if a resident was not informed of their medication administration they would not be informed of their care. During an interview on 4/4/2024 at 4:11 p.m. with the Director of Nursing (DON), the DON stated she expected licensed nurses to explain the medications to the residents prior to administration. The DON stated it was important to inform residents of the medications they take because residents recognized their medications and it was validation that they took their medications. The DON stated informing a resident of the medications they were about to take gave a resident self-worth to say what medication they want to take or what medication they did not want take. The DON stated informing a resident of their plan of care provided the right to be informed and the right to choose or be part of their care. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, dated 5/2016, the P&P indicated licensed nurses must explain to resident the type of medication being administered and the procedure.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure respect and dignity was provided for one of eight sampled residents (Resident 134) by not ensuring Resident 134 was served meals with disposable plastic utensils and not informing Resident 134 of the reason she received the disposable plastic utensils. This deficient practice violated Resident 134's right to be treated with respect and dignity and had the potential to negatively impact Resident 134's psychosocial well-being. Findings: During a review of Resident 134's Admission Record, the admission record indicated Resident 134 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue and muscle stiffness) and depression (a common and serious medical illness that negatively affects how a person feels, the way they think and act, causes feelings of sadness and/or a loss of interest in activities they once enjoyed). During a review of Resident 134's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/13/2024, the MDS indicated Resident 134's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 134 was dependent on staff for personal hygiene, toileting hygiene, and for showers. The MDS indicated Resident 134 needed set up or clean up assistance with eating. The MDS indicated Resident 134 had a diagnosis of paraplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease). During a review of Resident 134's History and Physical (H&P) dated 12/3/2023, the H&P indicated Resident 134 had the capacity to understand and make decisions. During a review of Resident 134's medical record, unable to locate any physician orders or care plans addressing the need for the use of plastic utensils. During an observation on 4/3/2024 at 12:44 p.m. in Resident 134's room, observed Resident 134's food tray with plastic disposable utensils. The food tray's meal ticket indicated to provide disposable utensils. During an interview on 4/3/2024 at 12:47 p.m. with Resident 134, in Resident 134's room, Resident 134 stated she had been receiving plastic disposable utensils with all meals for a long time and she did not know why. Resident 134 stated she would prefer to use regular silverware like the rest of the other residents. Resident 134 stated she felt bad that she had to use plastic disposable utensils. Resident 134 stated she felt like she had a disease and the facility did not want her to use their silverware. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 10:30 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was aware that Resident 134 received plastic disposable utensils. CNA 1 stated she did not know why Resident 134 received plastic disposable utensils with every meal. CNA 1 stated the only residents that received plastic disposable utensils were residents in isolation due to COVID-19 (a highly infectious disease caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death). CNA 1 stated she did not inform the licensed nurses that Resident 134 received plastic disposable utensils. During an interview on 4/4/2024 at 10:34 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she did not know Resident 134 received plastic disposable utensils with her meals. LVN 2 stated if Resident 134 used plastic disposable utensils there had to be a care plan, a physician order, and nurses progress notes indicating the use of plastic disposable utensils. LVN 2 stated no one notified her Resident 134 used plastic disposable utensils. During an interview on 4/4/2024 at 11:02 a.m. with the Dietary Supervisor (DS), the DS stated residents with a mental disorder or residents in isolation were the only residents that used plastic disposable utensils. The DS stated she did not know Resident 134 received plastic disposable utensils. The DS stated looking at the meal ticket it should tell her that Resident 134 should not receive plastic disposable utensils because the meal ticket had Resident 134's room number. The DS stated it was important not to provide plastic disposable utensils to Resident 134 because it would make Resident 134 feel bad and it did not provide dignity during mealtime. During an interview on 4/4/2024 at 12:24 p.m. with the DS, the DS stated Resident 134 had received plastic disposable utensils since 1/2024. The DS stated Resident 134 received plastic disposable utensils because she had verbalized suicidal ideations. The DS stated when a resident was on suicide watch, the facility took away silverware and provided plastic disposable utensils for prevention. During a concurrent interview and record review on 4/4/2024 between 12:59 p.m. and 1:34 p.m., with LVN 2, Resident 134's Care Plans, Physician Orders, and Nursing Progress Notes were reviewed. LVN 2 stated there was not a care plan, physician order, or nursing notes addressing the use or need of plastic disposable utensils. During an interview on 4/4/2023 at 4:29 p.m. with the Director of Nursing (DON), the DON stated when a resident had suicidal ideations their silverware was changed to plastic disposable utensils. The DON stated plastic disposable utensils were given to the resident as an intervention to prevent the resident from hurting themselves. The DON stated once Resident 134 was not in danger, she should have stopped receiving plastic disposable utensils. The DON stated the licensed nurses should have notified the dietary department to stop providing the plastic disposable utensils and provide silverware with all meals. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, dated 1/2024, the P&P indicated each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The P&P indicated demeaning practices and standards of care that compromise dignity is prohibited. The P&P indicated staff shall promote dignity and assist residents as needed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to respect a residents' right to personal privacy for one out of eight sampled residents (Resident 90) by failing to ensure the facility's case manager did not open Resident 90's mail. This deficient practice violated Resident 90's right to privacy and had the potential to cause psychosocial harm to Resident 90. Findings: During a review of Resident 90's Admission Record, the admission record indicated Resident 90 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs) and congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should). During a review of Resident 90's History and Physical (H&P) dated 3/6/2024, the H&P indicated Resident 90 did the capacity to understand and make decisions. During a review of Resident 90's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/17/2024, the MDS indicated Resident 90's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 90 required partial/moderate assistance (helper does more than half the effort) for personal hygiene. The MDS indicated Resident 90 was dependent on staff for toileting hygiene, lower body dressing, showers/baths, and putting on/taking off footwear. During an interview on 4/1/2024 at 12:08 p.m. with Resident 90, in Resident 90's room, Resident 90 stated she received her mail opened a couple of times. Resident 90 stated she informed the case manager not to open her mail and the case manager stated it was not a problem that she opened her mail. Resident 90 stated she had to ask the case manager a couple of times not to open her mail because the case manager continued to do so. Resident 90 stated she felt violated and upset because she had to ask the case manager a couple of times to not open her mail. Resident 90 stated the case manager opened her mail and kept it on her desk until Resident 90 went to her office to claim her mail. Resident 90 stated the case manager told her if she stopped opening Resident 90's mail then the resident needed to open her mail in front of her. During an interview on 4/4/2024 at 11:53 a.m. with the Case Manager, the Case Manager stated she opened Resident 90's mail because she wanted to verify the resident's medical appointments. The Case Manager stated she knew that it was Resident 90's right to receive closed mail but she still opened it. The Case Manager stated she did not have Resident 90's permission to open her mail but she still opened the resident's mail. The Case Manager stated she asked Resident 90 to open her mail in front of her so she could see when her appointments were. The Case Manager stated Resident 90 was upset when she discovered she opened her mail. The Case Manager stated she understood she violated Resident 90's right to privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 4:19 p.m. with the Director of Nursing (DON), the DON stated the person that distributed mail must hand deliver mail to all residents. The DON stated all mail must be delivered unopened. The DON stated mail should not be open by staff for resident privacy and it was the residents right to receive closed mail. The DON stated if staff opened residents mail, there was a possibility of residents not to receive their mail and the residents would not be able to exercise their freedom to receive unopened mail. During a review of the facility's Policy and Procedure (P&P) titled, Mail, dated 1/2024, the P&P indicated residents may send and receive their personal mail unopened. The P&P indicated mail would be delivered to the resident unopened unless otherwise indicated by the attending physician and documented in the resident's medical record. The P&P indicated staff members will not open mail for the resident unless the resident request them to do so. The P&P indicated mail received in the facility will be delivered to the resident within twenty four hours.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to develop and/or implement an individualized person-centered care plan (document helps nurses and other team care members organize aspect of resident care) with measurable objectives, timeframes, and interventions to meet the residents' needs addressing one out of eight sampled residents (Resident 134) suicidal ideations (Intrusive thoughts and a preoccupation with death and dying). This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 134. Findings: During a review of Resident 134's Admission Record, the admission record indicated Resident 134 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue and muscle stiffness) and depression (a common and serious medical illness that negatively affects how a person feels, the way they think and act, causes feelings of sadness and/or a loss of interest in activities they once enjoyed). During a review of Resident 134's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/13/2024, the MDS indicated Resident 134's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 134 was dependent on staff for personal hygiene, toileting hygiene, and showers. The MDS indicated Resident 134 required set up or clean up assistance with eating. The MDS indicated Resident 134 had a diagnosis of paraplegia (paralysis [inability to move] of the legs and lower body, typically caused by spinal injury or disease). During a review of Resident 134's History and Physical (H&P) dated 12/3/2023, the H&P indicated Resident 134 had the capacity to understand and make decisions. The H&P indicated Resident 134 had a diagnosis of anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 134's Change of Condition (COC) assessment, dated 1/1/2024, the COC indicated Resident 134 verbalized to staff that she felt anxious and wanted to kill herself because her family did not come to visit her for New Years. The COC indicated Resident 134 verbalized feeling sad. The COC indicated Resident 134 stated if she could walk, she would walk to a cross walk and stand there until a car hit her. During a review of Resident 134's Every 15 minutes monitoring forms, dated 1/1/2024 - 1/4/2024, the monitoring forms indicated Resident 134 was monitored every 15 minutes from 1/1/2024 to 1/4/2024. The monitoring forms indicated Resident 134 verbalized wanting to hurt herself. During a review of Resident 134's Progress Notes, dated 1/2/2024, the progress notes indicated Resident 134 refused to be taken to the hospital for further psychiatric evaluation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 134's Care Plans, unable to locate a care plan addressing Resident 134's suicidal ideations. During an interview on 4/4/2024 at 12:24 p.m. with the Dietary Supervisor (DS), the DS stated Resident 134 received plastic disposable utensils since 1/2024 because the resident verbalized suicidal ideations. The DS stated when a resident was on suicidal watch, the facility took away silverware and provided plastic disposable utensils for prevention of the residents hurting themselves. During an interview on 4/4/2024 at 12:59 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was not aware that Resident 134 verbalized wanting to kill herself. LVN 2 stated no one communicated with her that Resident 134 wanted to hurt herself. LVN 2 stated when a resident verbalized wanting to hurt themselves it was supposed to be communicated to all staff because it was important for everyone to know. During a concurrent interview and record review on 4/4/2024 at 1:11 p.m. with LVN 2, Resident 134's Care Plans were reviewed. LVN 2 stated there was not a care plan addressing suicidal ideations. LVN 2 stated suicidal ideations must be care planned to offer licensed nurses a plan of care to follow. LVN 2 stated when there was no care plan developed, licensed nurses were not aware of the issue and the resident may not receive the care and attention that was needed. During an interview on 4/4/2024 at 1:38 p.m. with Resident 134, in Resident 134's room, Resident 134 stated she verbalized feelings of wanting to hurt herself in January 2024. Resident 134 stated she was upset during the holidays because she missed her family. During an interview on 4/4/2024 at 4:25 p.m. with the Director of Nursing (DON), the DON stated suicidal ideations must be care planned. The DON stated it was important to develop a care plan for suicidal ideations in order to develop a plan of care and proper interventions for Resident 134. The DON stated if a resident's suicidal ideations was not care planned, it did not provide what interventions to follow for prevention of residents hurting themselves. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, dated 1/2024, the P&P indicated a care plan must be developed to manage risks and promote improvement in general condition. The P&P indicated an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The P&P indicated each resident's comprehensive care plan had been designed to incorporate identified problem areas, incorporate risk factors associated with identified problems and behavior history, reflect treatment goals and objectives in measurable outcomes, identify the professional services that are responsible for each element of care, and aid in preventing or reducing declines in the resident's functional status and/or functional levels.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to maintain appropriate grooming and personal hygiene for two of 12 sampled residents (Residents 88 and 222) by failing to keep the residents' nails clean and neat. This failure had the potential to result in negative impact on the residents' quality of life and self-esteem and had the potential for development of infection. Findings: a. During a review of Resident 88's Admission Record (Face Sheet), the Admission Record indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to cellulitis of the left lower limb (skin infection that spreads rapidly), type 2 diabetes mellitus (a condition that results in too much sugar circulating in the blood), and cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area). During a review of Resident 88's Minimum Data Set (MDS, a standardized screening and assessment tool), dated 1/18/2024, the MDS indicated Resident 88 was able to make himself understood and understood others. The MDS indicated Resident 88's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 88 required moderate assistance with personal hygiene where he provided less than half the effort. During a review of Resident 88's History and Physical (H&P), dated 1/5/2024, the H&P indicated Resident 88 had the capacity to understand and make decisions. During a concurrent observation and interview on 4/1/2024 at 9:50 a.m. and on 4/2/2024 at 8:35 a.m., with Resident 88, in Resident 88's room, Resident 88 was observed with a black substance underneath his ten fingernails. Resident 88 stated no one cut or cleaned or helped him cut or clean his nails. During a concurrent observation and interview on 4/3/2024 at 8:17 a.m., with Psychiatric Assistant (PA) 1, in Resident 88's room, Resident 88 had black substance observed underneath his ten fingernails. PA 1 stated Resident 88's nails were dirty, and the resident's nails required cleaning and trimming. PA 1 stated nail care was one of the PA's duties, where they looked over the resident's nails and if they were long or dirty, they would clip, trim, and clean the nails. PA 1 stated residents' nails should be looked at daily to keep the residents' nails clean and neat. PA 1 stated sometimes the residents scratch their skin and if they scratch themselves hard enough, they could create an open wound. PA 1 stated if a resident had dirty fingernails and scratched themselves, that increased their risk of infection. PA 1 stated having dirty fingernails was not sanitary because the resident will use their hands to hold their utensils when eating and any bacteria could transfer into their body. PA 1 stated having dirty fingernails was not sanitary to other residents because if Resident 88 were to touch objects that other residents touch, the bacteria under his fingernails could transfer to the object and then to the other resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/2024 at 8:27 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the residents' nails should be checked every day if they needed to be trimmed or cleaned. LVN 3 stated if a resident had black substance under their nails for three days, it was an issue because there was the possibility that the black substance was feces. LVN 3 stated Resident 88's dirty fingernails were an issue because Resident 88 could rub his eye and he could end up with an eye infection. LVN 3 stated Resident 88 could touch other residents or other items and transfer any bacteria on his hands to others. LVN 3 stated Resident could scratch himself and develop a wound that could get infected. During an interview on 4/3/2024 at 8:39 a.m., with Registered Nurse (RN) 1, RN 1 stated residents' nails should be checked every day by the PAs and the black substance under Resident 88's fingernails should have been noticed. RN 1 stated nail care was important, especially when they are eating because the bacteria present on the resident's fingernails could go into the food and could cause infection after consumption. RN 1 stated dirty fingernails increased the chance for cross contamination with other objects and other residents. During an interview on 4/4/2024 at 3:56 p.m., with the Director of Nursing (DON), the DON stated nail care should be assessed daily and if the resident required assistance with cleaning or trimming their nails, the PAs, certified nursing assistants, or licensed nurses could assist them. The DON stated nail care was important because the residents' nails were a source of infection and having dirty fingernails could affect how the residents see themselves. The DON stated the residents' hygiene was very important and Resident 88's dirty fingernails should have been taken care of. The DON stated Resident 88's fingernails should have been assessed and the staff should have offered their assistance if he was unable to perform the task. 48343 b. During a review of Resident 222's Admission Record (Face Sheet), the Face Sheet indicated Resident 222 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a group of diseases that cause airflow blockage and breathing-related problems), schizophrenia (a mental condition that affects a person's ability to think), depression (feeling sadness and loss of interest), dementia (loss of memory), and muscle weakness (a lack of muscle strength). During a review of Resident 222's MDS, dated [DATE], the MDS indicated Resident 222 required setup assistance from staff for toileting, oral, and personal hygiene. During a review of Resident 222's H&P dated 2/12/2024, the H&P indicated Resident 222 had the capacity to understand and make decisions. During an observation on 4/1/2024 at 12:02 p.m., in Resident 222's room. Resident 222 was observed lying in bed with both feet uncovered. Resident 222's toenails were observed long with brown colored substance under the toenails. Resident 222 stated he did not remember when the last time his toenails were cleaned or cut. Resident 222 stated his toenails looked long and dirty. Resident 222 stated he would like to have his toenails cleaned and cut by staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2024 at 8:39 a.m., in Resident 222's room, with Certified Nursing Assistant (CNA) 2. CNA 2 stated CNAs were responsible for cleaning resident toenails. CNA 2 acknowledged that Resident 222's toenails were long and had a brown substance under his toenails. CNA 2 stated residents' skin and toenails should be assessed daily, during showers, and cleaned daily. CNA 2 stated long toenails must be reported to the charge nurse and documented on the CNAs flowsheet. CNA 2 stated the podiatrist (a person who treats the feet and their ailments) trim the residents' toenails every month and as needed. CNA 2 stated she did not know when the last time Resident 222 was seen by the podiatrist and was not able to remember if she reported to the charge nurse. CNA 2 stated it was important Resident 222's toenails were clean and trim to prevent infection, cuts, and injury. During a concurrent interview and record review on 4/3/2024 at 8:42 a.m. with CNA 2, Resident 222's CNA flowsheet for month of 3/2024, and 4/2024 was reviewed. There were no CNAs documentation to demonstrate Resident 222's toenails status was reported. CNA 2 stated if it was not documented, it was not done. During a concurrent interview and record review on 4/3/2024 at 8:53 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 222's Order Summary Report, dated 3/26/2024 was reviewed. The order summary report indicated podiatry care every two months and as needed (PRN) for mycotic (infection with a fungus), hypertrophic (increase in the size) nails, corns (excess skin), and, or callous (area of thickened skin). LVN 3 stated CNAs assess and care for residents' toenails daily, and during personal hygiene. LVN 3 stated CNAs must report long toenails to the change nurse right away. LVN 3 stated the change nurse must assess the resident toenails and report to Social Services (SS) immediately. LVN 3 stated SS must schedule a podiatrist visit right way. LVN 3 stated long and dirty toenails was a safety risk, placing the resident at risk for infection. LVN 3 stated Resident 222 could scratch himself, could get injured, and long toenails could grow bacteria, fungus (living things produce organisms), and infection. During an interview on 4/3/2024 at 9:05 a.m. with the SS, the SS stated certified staff should report to her when residents needed a podiatrist visit. The SS stated the podiatrist came to the facility every month and PRN. The SS stated if certified staff did not report to her when residents needed a podiatrist visit PRN, the SS would not know to schedule an appointment for the resident. During an interview on 4/4/2024 at 9:11 a.m. with the Director of Nursing (DON), the DON stated it was the CNAs' responsibility to make sure the residents' toenails were cleaned daily and trimmed as needed. The DON stated residents should be provided with care and services necessary to maintain good personal hygiene. During a review of facility's policy and procedure (P&P) tilted, Activity of Daily Living (ADLs), dated 2/2024, the P&P indicated the facility was to provide assistance to residents in meeting their ADL needs with respect and dignity including personal hygiene- bathing, grooming, oral, nails and hair care. The P&P indicated the following: 1. Complete the shower sheet on shower days. Indicate any issues identified during shower and turn in to the change nurse. 2. Document the care provides.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to assess and identify the potential hazard and resident's risk factors for falls for one of three sampled residents (Resident 36), by failing to complete a Post-Fall Assessment and conduct an Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) meeting after Resident 36 had an unwitnessed fall. This failure had the potential for Resident 36's cause of fall to be undetermined and increased the potential for reoccurrence of future falls and injury. Findings: During a review of Resident 36's Admission Record (Face Sheet), the Admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarction (also known as a stroke, refers to damage to the tissues in the brain due to a loss of oxygen to the area), metabolic encephalopathy (problem in the brain caused by chemical imbalances in the blood), and schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). During a review of Resident 36's Minimum Data Set (MDS, a standardized screening and assessment tool), dated 2/29/2024, the MDS indicated Resident 36 was able to understand and was usually understood by others. The MDS indicated Resident 36's cognition (process of thinking) was severely impaired. The MDS indicated Resident 36 had impairment on both lower extremities (legs) and used a wheelchair for mobility. During a review of Resident 36's History and Physical (H&P), dated 4/2/2024, the H&P indicated Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's Change of Condition (COC) Assessment, dated 3/31/2024, the COC indicated Resident 36 was found on his knees on the floor of his room. The COC indicated Resident 36's physician was notified and new orders for a 72-hour neurological check (assessment tool to identify any changes in a way a person thinks, speaks, and moves) and to place Resident 36 on one-to-one (1:1) monitoring (close monitoring of a resident). During a review of Resident 36's Care Plan, the care plan indicated Resident 36 had an unwitnessed fall on 3/31/2024. The care plan goal indicated Resident [36] will resume his usual activities without any further episodes of falls. The staff's interventions indicated, [To] attempt to determine and address causative factors of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 11:37 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated in the event a resident fall, the licensed nurse was responsible for conducting a pain and skin assessment, complete the COC, and complete the fall assessment, also known as the Morse Fall Scale. LVN 3 stated the Morse Fall Scale was conducted upon admission to the facility, quarterly, and post-fall. LVN 3 stated the Morse Fall Scale was used to assess the resident's risk factors for falls and to generate a score that would indicate whether the resident was a low, moderate, or high risk for falls. LVN 3 stated a Morse Fall Scale was completed post-fall to compare his risk factors from the previous assessment and the post-fall Morse Fall Scale would help the nurses determine if the resident required more assistance and direct the plan of care. LVN 3 stated he did not do a post-fall Morse Fall Scale assessment for Resident 36 because he probably forgot, however, the post-fall Morse Fall Scale should have been completed on 3/31/2024. During an interview on 4/4/2024 at 11:54 a.m., with the Assistant Director of Nursing (ADON), the ADON stated after a resident had fallen, the licensed nurse would assess the resident's skin, pain, and conduct a post-fall assessment. The ADON stated the residents Morse Fall Scale was completed upon admission, quarterly, and post-fall. The ADON stated completing the Morse Fall Scale post-fall was important to determine if the resident was scored as a high fall risk. The ADON stated the Morse Fall Scale would then direct the nurses to determine the interventions best suited to prevent further falls for the resident. The ADON stated Resident 36 was not reassessed for his fall risk after his fall on 3/31/2024. The ADON stated the lack of reassessment placed Resident 36 at risk of further falls because they could have missed other risk factors that contributed to the fall that were not identified. The ADON stated she was responsible for coordinating the post-fall IDT meetings. The ADON stated a post-fall IDT meeting was conducted to identify the causation for the fall and to determine the interventions best suited for the resident. The ADON stated she was not made aware of Resident 36's fall on 3/31/2024, therefore, an IDT meeting was not conducted. The ADON stated because the post-fall IDT meeting was not conducted, the IDT was unable to discuss Resident 36's fall and the measures to prevent further falls. During an interview on 4/4/2024 at 4:08 p.m., with the Director of Nursing (DON), the DON stated the post-fall assessment was supposed to be completed to identify risk factors and to develop a better plan of care for the resident. The DON stated the post-fall assessment would allow the nurses to implement other fall preventions interventions in addition to the pre-fall interventions to better care for the resident. The DON stated it was an issue if a post-fall assessment was not completed because the proper post-fall interventions would not be implemented. The DON stated one of the goals of completing the post-fall assessment was to minimize injury from any reoccurrence of falls. The DON stated a post-fall IDT meeting should be conducted whenever a resident falls. The DON stated the IDT would discuss the fall, create a plan of care, and notify the resident's physician of their recommendation. The DON stated the IDT would discuss the resident's risk factors, the Morse Fall Scale, the resident's overall condition, and any changes in their behavior or medications. The DON stated an IDT meeting had not been conducted for Resident 36. The DON stated without the IDT meeting to discuss Resident 36's fall, there was the potential he could have another fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Accident Management, reviewed on 1/2024, the P&P indicated, It is the policy of this facility to identify and assess residents who are at risk for falls/injuries, implement preventative interventions, and effectiveness of safety interventions. All Residents will be assessed for fall risk factors upon admission, quarterly, change of condition and annually, utilizing the Fall Risk assessment form . The IDT will conduct a post fall IDT meeting to review risk factors, appropriateness of current interventions and provide further recommendations based on new risk factors identified.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to: 1. Ensure medications brought from home (Home Medications) were reviewed by the pharmacist for two of two residents (Resident 65 and Resident 113) prior to administering Home Medications stored inside of two of four medication carts inspected (Medication Cart 2 located on Station 3 and Medication Cart 3 on Station 1) respectively. 2. Accurately account for and document the administration of eight out of 12 doses of Lorazepam, a controlled medication (has a high potential for abuse) affecting Resident 36 on Station 2, Medication Cart 2. These deficient practices increased the risk for unsafe medication administration, potential for diversion, medication errors due to lack of documentation, possibly resulting in serious health complications that could lead to hospitalization or death. Findings: a. During a review of Resident 65's Admission Record, the admission record indicated Resident 65 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included Alzheimer's Disease (progressive memory loss), rheumatoid arthritis (swelling and tenderness of one or more joints) of the right knee, age-related osteoporosis (bone loss), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 65's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 1/16/2024, the indicated Resident 65's cognition (ability to think and reason) was severely impaired and was dependent upon facility staff for all activities of daily living (ADLs, self-care activities performed daily such as dressing, toileting, and personal hygiene). During a concurrent inspection and interview on 4/3/20204 at 12:20 PM, of Medication Cart 2, on Station 3, with Licensed Vocational Nurse (LVN) 12, inside Medication Cart 2 in the bottom drawer was a basket that contained prescription bottles of medication labeled for Resident 65. LVN 12 stated the medications in the basket were medications brought into the facility by Resident 65's, or her family and the facility was currently administering the Home Medication to Resident 65. LVN 12 stated the licensed nurses reviewed the Home Medications brought into the facility and the medications were not sent to the facility's pharmacy for review. The prescription medications observed in the basket included: 1. Torsemide (used to treat fluid retention) 20 milligrams (mg, unit of measure by weight), instructions to give one tablet by mouth once a day. 2. Losartan Potassium (used to treat high blood pressure) 50 mg, give one tablet by mouth once daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Potassium Chloride (used to treat and prevent low blood potassium) Extended Release 20 milliequivalent (mEq, a unit of measure) , give one tablet by mouth twice daily. Hold Potassium Chloride if Torsemide is being held. 4. Xarelto (used to treat and prevent blood clots to lower the risk of stroke [occurs when the blood supply to part of the brain is blocked or reduced]) 10 mg, five one tablet by mouth once daily. During a review of Resident 65's Order Summary Report dated 3/25/2024, the order summary report indicated the following orders: 1. Torsemide 20 mg, order date 4/5/2022, instructions indicated to give one tablet by mouth one time a day for heart failure, hold if Systolic Blood Pressure (SBP, the pressure when the heart is pumping blood to the body) is less than 110 millimeters of mercury (mmHg, unit of pressure). Hold KCL (Potassium Chloride) when Torsemide is held. 2. Potassium Chloride ER Tablet Extended Release 20 MEQ, order date 1/7/2024, instructions indicated to give 1 tablet by mouth two times a day for potassium (k+) supplement, HOLD KCL IF TORSEMIDE IS BEING HELD. DO NOT CRUSH. 3. Losartan Potassium Tablet 50 MG, order date 3/2/2021, instructions indicated to give 1 tablet by mouth one time a day for hypertension Hold if SBP is less than 110 mmHg. 4. Rivaroxaban (Xarelto) Tablet 10 MG, order date 5/21/2019, instructions indicated to give 1 tablet by mouth in the evening for atrial fibrillation (A-Fib, an irregular, often rapid heart rate that commonly causes poor blood flow). During a concurrent interview and record review on 4/3/2024 at 12:25 PM, with LVN 12, Resident 65's current physician orders were reviewed. LVN 12 reviewed Resident 65's physician order and stated the Home Medication prescription labels did not match the current physician's orders. LVN 12 stated there was no instruction on the prescription label to indicate when to hold the Torsemide, Potassium Chloride, or Losartan Potassium. LVN 12 stated for Resident 65 the Home Medication prescription labels and the physician's current orders should match. b. During a review of Resident 113's Admission Record, the admission record indicated Resident 113 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, contracture (shortening or tightening of tissues that reduces movement in an area), and functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition). During a review of Resident 113's MDS dated [DATE], the MDS indicated Resident 113 cognition was severely impaired. The MDS indicated Resident 113 was dependent upon facility staff for all ADLs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent inspection and interview at Station 1, Medication Cart 3, on 4/3/2024, at 3:46 PM, with LVN 13, LVN 13 stated Resident 113's family brought in the medications for the resident. LVN 13 stated the facility's licensed nurses would contact Resident 113's family when medication for the resident was needed. LVN 13 stated she was not aware how the Home Medications brought in by the resident's family were to be handled or documented. LVN 13 reviewed Resident 113 Home Medication bottles and stated there were no stickers on the Home Medication bottles to indicate the medications were reviewed by the facility's pharmacist for accuracy. Resident 113's Home medications observed in Medication Cart 3 on Station 1 included the following: 1. Lisinopril (used to treat high blood pressure) 5 mg. 2. Atorvastatin (used to treat high cholesterol) 40 mg. 3. Mirtazapine (used to treat depression) 15 mg. 4. Tramadol (controlled medication for pain) 50 mg. During a review of Resident 113's Order Summary Report dated 3/26/2024, the order summary report indicated the following orders: 1. Lisinopril Tablet 5 MG, order date 11/3/2020, give 1 tablet by mouth one time a day for HTN (hypertension, high blood pressure). Hold if SBP is less than 110 mmHg. 2. Atorvastatin calcium Tablet 40 MG, order date 11/3/202, give 1 tablet by mouth at bedtime for hyperlipidemia (high cholesterol). 3. Remeron Oral Tablet 15MG (Mirtazapine), order date 6/1/2023, give 1 tablet by mouth at bedtime for depression manifested by (m/b) poor PO (oral) intake eating less than 50 percent (%) of meals. 4. Tramadol HCl Tablet 50 MG, order date 1/10/2022, give 1 tablet by mouth two times a day for pain management. During a concurrent interview and record review on 4/3/2024 at 4 PM, with LVN 13, Resident 113's current physician orders and Home Medication prescription labels were reviewed. LVN 13 stated Resident 113 prescription labels did not match the physician's current orders. LVN 13 stated Resident 113 Home Medication label did not include the hold or administer parameter for Lisinopril as ordered and Tramadol's label indicated to give as needed and not two times a day routinely as ordered by the physician. During an earlier interview on 4/3/2024 at 3:19 PM with LVN 1, LVN 1 stated the facility did not accept medications that were brought in by the resident's family because the facility did not know what medications were inside of the bottles. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/2024 at 4:38 PM with the Director of Nursing (DON), the DON stated Home Medications, according to the facility's policy, must be verified by the facility's pharmacy and the pharmacist usually writes a letter to indicate the medications were verified and safe for resident use. The DON stated there was no pharmacist letter to indicate Resident 65 and Resident 113's medications were verified by the pharmacist prior to administering to the residents. The DON stated residents' prescription labels, must match the physician's current orders or the residents may be administered medications incorrectly and experience adverse reactions. During a review of the facility's policy and procedure (P&P) titled, Medications Brought in By Resident or Family, dated 1/2024, the P&P indicated medications brought into the facility by a resident or responsible party are accepted only with a current order by the resident's prescriber, after the contents are verified by the prescriber or pharmacist, and if the packaging meets the state, federal and pharmacy guidelines. c. During a concurrent interview and record review on 4/4/2024 at 3:08 PM, with LVN 3 on Station 2, Resident 36's Controlled Drug Record (CDR), Medication Administration Record (MAR) for the months of 3/20204 and 4/2024 and the resident's physician order for Lorazepam 1 mg was reviewed. LVN 3 stated Resident 36 was documented to have been administered four doses of Lorazepam between 3/26/2024 to 4/2/2024 as indicated by nurses' initials documented on the resident's MAR for the dates of 3/26/24, 3/27/2024, 4/1/2024 and 4/2/2024. During a review of Resident 36 Order Summary, the order summary indicated Lorazepam Oral Tablet 1 mg, order date 3/21/2024, to give 1 (one) tablet by mouth every 6 (six) hours as needed for anxiety for 14 days, m/b constant fidgeting. During a concurrent interview and record review on 4/4/2024 at 3:09 PM, with LVN 3, Resident 36's CDR and MAR, for the months of 3/2024 and 4/2024, was reviewed. LVN 3 stated 12 doses of Lorazepam was documented as removed from the bubble pack for administration to Resident 36 instead of the four that was documented on the resident's MAR. LVN 3 pointed to the doses of Lorazepam that he documented on the CDR. LVN 3 stated he removed and administered six of the Lorazepam to Resident 36 but forgot to document the administrations on the residents MAR for the following days: two doses on 3/25/2024 at 9 AM and 5 PM; one dose on 3/26/2024 and 3/29/2024 at 9 AM; and one dose on 3/30/2024 and 4/2/2024 at 7 AM. During an interview on 4/4/2024 at 3:16 PM, LVN 3 stated inaccurate documentation on the MAR for Resident 36 could lead to double dosing the resident, increased risk of side effects that include the resident feeling lethargic, sleepy, potential for a fall, and can lead to injury and hospitalization . LVN 3 stated he did not document Resident 36's Lorazepam administration on the resident's MAR or specify the behavior in the nursing progress notes to indicate the reason the medication was administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/4/2024 at 4:53 PM with the Director of Nursing (DON), Resident 36's MAR, CDR, nursing progress notes, and physician orders were reviewed. The DON stated Resident 36's CDR indicated 12 tablets of Lorazepam 1 mg was removed and the resident's MAR indicated 4 doses of Lorazepam 1 mg was documented as administered to Resident 36. The DON stated this would be a medication error and the resident could experience adverse reactions that included sedation, dizziness, respiratory depression, aggressive behavior, behavior changes, and could contribute to a fall. The DON stated there was not enough information documented on Resident 36's MAR or no documentation in nursing progress notes to help the physician form a clinical judgement as to why the resident needed the Lorazepam. During a review of the facility's P&P titled, Controlled Medication Storage, dated 11/2017, the P&P indicated, Medications included in the state and federal Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal, stated and other applicable laws and regulations. During a review of the facility's P&P titled, Medication Administration General Guidelines, dated 5/2016, the P&P indicated, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review, the facility failed to: 1. Ensure lorazepam (a medication used to treat mental illness) was used for a medical condition as diagnosed and documented in the resident's clinical record between 3/25/2024 and 4/2/2024, for one of five residents sampled for unnecessary medications (Resident 36). 2. Define resident-specific target behaviors regarding the use of lorazepam for one of five residents sampled for unnecessary medications (Resident 36). 3. Monitor lorazepam for adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) and effectiveness between 3/35/2025 and 4/2/2024, for one of five residents sampled for unnecessary medications (Resident 36). 4. Quantify episodes of constant fidgeting, per the physician's order related to the use of lorazepam (a medication used to treat anxiety, excessive worry and feelings of fear, dread, and uneasiness) between 3/21/2024 and 4/2/2024, for one of five residents sampled for unnecessary medications (Resident 36). These deficient practices increased the risk that Resident 36 may have or have experienced adverse effects related to psychotropic medications possibly contributed to an unwitnessed fall on 3/31/2024, and/or leading to experiencing impairment or decline in his mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 36's Admission Record, the admission record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), difficulty in walking, muscle weakness, and chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). During a review of Resident 36's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 2/29/2024, the MDS indicated Resident 36 cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired and required facility staff supervision for activities of daily living (ADLS, tasks of everyday life that include eating, dressing, getting in and out of bed or chair, bathing, and toileting). During a review of Resident 36 Order Summary, the order summary indicated the following orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Lorazepam Oral Tablet 1 milligrams (mg, unit of measurement), give 1 (one) tablet by mouth every 6 (six) hours as needed for anxiety for 14 days, manifested by (m/b) constant fidgeting, order date 3/21/2024. 2. Monitor behavior episodes of constant fidgeting every shift for Lorazepam use for 14 days, order date 3/21/2024. 3. (Lorazepam) Antianxiety Medication - Monitor adverse reactions: Appetite Changes, Blurred Vision, Confusion, Dizziness, Drowsiness, Fatigue, Hypotension, Nightmares, Sedation, Slurred Speech, Urinary Retention, Dry Mouth, increased Risk for Falls. Document 'N' if none of the above observed. 'Y' If any of the above was observed, and document findings In nurses/progress note, every shift. During a review of Resident 36 Care Plan dated, 3/21/2024, the care plan indicated the resident was at risk for falls/injuries related to gait/balance problems, altered thought process with poor insight, psychotropic drug use, and history of unwitnessed falls on 2/6/2024 and 3/31/2024. Staff interventions indicated to anticipate, and meet the resident's needs, and resident needs prompt response to all request for assistance. During a review of Resident 36's Change of Condition Assessment form dated 3/31/2024 and timed at 5:00 PM, the form indicated Resident 36 experienced an unwitnessed fall inside of his room. The form indicated, At around 17:00 (5) PM, staff reported they heard a loud noise and when they approached the room, they observed the resident was on the floor. The form indicated staff described the resident as being on his knees . During a review of Resident 36's Medication Administration Record (MAR), dated 3/25/2024 to 4/2/2024, the MAR indicated zero documented behaviors of constant fidgeting every shift between 3/25/2024 to 4/2/2024. During a review of Resident 36's MAR, dated 3/25/2024 to 4/2/2024, for nonpharmacological (non-drug treatment) interventions for the use of Lorazepam, the MAR was let blank between 3/25/2024 to 4/2/2024. During a concurrent interview and record review on 4/4/2024 from 3:08 p.m. to 3:16 p.m., with Licensed Vocational Nurse (LVN) 3, in Station 2, Resident 36's Controlled Drug (CDR), Medication Administration Record (MAR), and physician Order Summary Report for the months of 3/2024 and 4/2024 were reviewed. LVN 3 stated the following: a. At 3:08 PM, LVN 3 reviewed Resident 36's MAR and stated that Resident 36 was documented to have been administered four doses of Lorazepam 1 mg on 3/2620/24, 3/27/2024, 4/1/2024 and 4/2/2024. b. At 3:09 PM, LVN 3 reviewed Resident 36's CDR and bubble pack of medication labeled for Resident 36 and stated that 12 doses of Lorazepam 1 mg were documented on Resident 36's CDR as removed, and the same number of doses was observed removed from the medication bubble pack labeled to contain Lorazepam 1 mg for Resident 36. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. At 3:11 PM, LVN 3 stated sometimes he forgot to document the administration of the controlled medication Lorazepam immediately after administration to Resident 36 on the resident's MAR. LVN 3 looked at Resident 36's CDR form for Lorazepam 1 mg and stated he did not document Resident 36 Lorazepam administration immediately after administration on the following dates and times: on 3/25/2024 at 9 AM; 3/25/2024 at 5 PM; 3/26/2024 at 9 AM; 3/29/2024 at 9 AM.; 3/30/2024 at 7 AM, and 4/2/2024 at 7 AM. d. At 3:16 PM, LVN 3 stated if Resident 36's Lorazepam dosages were not accurately documented on the CDR and MAR, the resident could be double dosed which could result in Resident 36 becoming lethargic, could increase risk for a fall or injury, and hospitalization . LVN 3 stated after administering Resident 36 Lorazepam between 3/25/2024 to 4/2/2024 that he did not document the behavior or reason for administering the as needed (PRN) medication to Resident 36 in the nursing progress notes or indicated if the medication was effective or not. LVN 3 stated that he should have documented the specific behavior observed in the nursing progress notes in order to keep track of how the resident was doing. LVN 3 stated he was on duty on 3/31/2024 when Resident 36 experienced an unwitnessed fall. LVN 3 stated he had administered a dose of Lorazepam to Resident 36 earlier that morning but did not document the administration on the MAR for 3/31/2024. LVN 3 stated he had not tried any non-pharmacological interventions prior to administering Lorazepam to Resident 36 each time. During an interview on 4/4/2024 at 3:36 PM with LVN 3, LVN 3 stated that he verbally talked with the psychiatrist regarding Resident 36, but did not always remember to document medication administration, resident behaviors, triggers, and interventions attempted prior to administering the PRN Lorazepam to Resident 36. During an interview on 4/4/2024 at 3:52 PM, with Psychiatric Assistant (PA) 2, PA 2 stated on 3/31/2024, during the evening shift, she heard a strong noise and found Resident 36 on the floor, and she then called for assistance and PA 1 and LVN 3 were among the staff that came to assist to get Resident 36 off the floor and back into bed. During an interview on 4/4/2024 at 4:18 PM, with LVN 3, LVN 3 stated Resident 36's Lorazepam could have contributed to the resident's fall on 3/31/2024, by increasing the resident's risk for dizziness, drowsiness, and unsteadiness while on the Lorazepam medication. During a concurrent interview and record review on 4/4/2025 at 4:53 PM, with the Director of Nursing (DON), Resident 36 MAR and CDR for the months of 3/2024 and 4/2024 were reviewed. The DON stated Resident 36's CDR indicated the resident was administered 12 doses of Lorazepam between 3/25/2024 to 4/2/2024, but only 4 pills were documented on the MAR as administered. The DON stated that would be a medication error and the resident could be negatively effect. The DON stated Resident 36 could experience adverse reaction that included hypertension (high blood pressure), sedation, dizziness, respiratory depression, seizures, aggressive behavior cognitive deficit, and behavior changes. The DON stated that Resident 36 was administered Lorazepam 1 mg daily which could have contributed to the resident's fall on 3/31/2024. The DON stated the licensed nurse should attempt nonpharmacological interventions before giving the PRN medication Lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/4/2024 at 5:04 PM, with the DON, Resident 36's nursing progress notes dated between 3/1/2024 to 4/2/2024 was reviewed. The DON stated there was no documentation in the nursing progress notes of what specific behavior was observed and what attempts were made to assist the resident or the reason for administering Lorazepam to Resident 36. The DON stated there was not enough information documented to help the physician form a clinical judgement as to why the resident needed the Lorazepam. During a review of the facility's Policy and Procedure (P&P), titled Psychotropic Use, dated, 1/2024, the P&P indicated, When antidepressant/antianxiety/hypnotics/antipsychotic medications (a medication(s) approved by the FDA for the treatment of psychosis) are used to restrain or control behavior or to treat a disordered thought process, the following shall apply: 1. The specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the resident's record; (Example: Buspar 5 mg. 1 hour prior to bedtime for screaming, secondary to hallucinations (Schizophrenia). 2. The plan of care for each resident specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions. 3. The number of behavior episodes will be collected, and presence of side effects shall be made available to the physician in a consolidated manner at least monthly. During a review of the facility's P&P titled, Medication Administration General Guidelines, dated 5/2016, the P&P indicated, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5 percent (%) during medication pass for four of five sampled residents (Residents 10, Resident 16, Resident 53, and Resident 621) observed during medication administration by failing to: 1. Ensure Resident 621's physician orders for hydroxychloroquine and potassium chloride extended release (ER) were administered in accordance with manufacturer's specification, the facility's policy and procedure (P&P) titled Medication Administration-General Guidelines, dated 5/2016, and/or the form titled, Medications Not To Be Crushed, list dated 7/2015 (Cross Ref F-tag F760). 2. Ensure Resident 621's physician order for aspirin was administered as prescribed on 4/2/2024. 3. Ensure Resident 10 was administered Metformin (a medication used to treat diabetes, a chronic [long-term] condition, in which a high level of glucose [sugar] is present in the bloodstream), within 60 minutes of the scheduled time as per the facility's P&P titled, Medication Administration-General Guidelines, dated 5/2016. 4. Ensure Resident 16 was administered the ordered dose of 250 milligram (mg, unit of measurement) of docusate sodium (used to treat or prevent constipation) instead of the lesser dose of 100 mg of docusate sodium on 4/2/2024. 5. Ensure Resident 16 was identified using at least two identifiers prior to medication administration as per the facility's P&P titled, Medication Administration-General Guidelines, dated 5/2016. 6. Ensure Resident 53's physician orders for Carafate Oral Suspension, Multivitamin Liquid, and Vitamin C Liquid were each shaken well before use in accordance with manufacturer's specification. These deficient practices of a medication administration error rate of 20.51 % exceeded the five (5) percent threshold. Findings: 1. During a review of Resident 621's Admission Record dated 4/2/2024, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time) without heart failure. During a review of Resident 621's Order Summary Report (a document containing a summary of all active physician orders), dated 3/27/2024, the order summary report indicated, Resident is NOT capable of giving informed consent and/or not able to participate in treatment plan. Resident's legal guardian or appointed representative has been made aware of the resident's medical condition. During a review of Resident 621's Order Summary Report, dated 3/27/2024, the order summary report indicated the following list of medications: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Potassium Chloride (supplement used to treat low potassium levels) Oral Tablet ER 10 milliequivalent (MEQ, a unit of measurement), give 1 tablet by mouth two times a day for supplement, order date 3/26/2024. 2. Losartan Potassium (used to treat high blood pressure) Oral Tablet 25 milligram (MG, a unit of measurement), give 1 tablet by mouth two times a day for hypertension (HTN, when the pressure in blood vessels is too high), Hold for systolic blood pressure (SBP, pressure in the arteries when heart beats) less than (<) 110, order date 3/26/2024. 3. Clopidogrel Bisulfate (used to keep blood vessels open), Oral Tablet 75 MG, give 1 tablet by mouth one time a day for cerebral vascular accident (CVA, a medical condition with problem in blood flow to brain cells) Prophylaxis (prevention), order date 3/26/2024. 4. Hydroxychloroquine Sulfate (used to autoimmune conditions) Oral Tablet 200 MG, give 2 tablets by mouth in the morning for Sjogren's syndrome (a medical condition affecting the immune system with symptoms of dry eyes and a dry mouth) 2 tabs, total of 400 mg, order date 3/26/2024. 5. Pilocarpine Hydrochloride (HCL) (used to treat dry mouth) Oral Tablet 5 MG, give 1 tablet by mouth three times a day for Sjogren's Syndrome, order date 3/26/2024. 6. Aspirin Oral Tablet 325 MG, give 1 tablet by mouth in the morning for CVA Prophylaxis, order date 3/26/2024. During an observation on 4/2/2024 at 8:35 AM, Licensed Vocational Nurse (LVN) 6 crushed seven different medications including Potassium Chloride ER tablets and Hydroxychloroquine for a total of eight pills altogether with the intent to administer as a mixture with applesauce for Resident 621. Medication cards for Potassium Chloride ER and Hydroxychloroquine tablets indicated Do not Chew or Crush. LVN 6 was stopped by the surveyor at bedside from her intent to administer the crushed mixture of multiple medications including those on Do not crush list to Resident 621. Under further review, it was observed that LVN 6 also crushed the following medications, which were not listed on the order summary report dated 3/27/2024. LVN 6 then removed Potassium Chloride ER and Hydroxychloroquine tablets from the list of medications and crushed the crushable medications together before administering as a mixture to Resident 621. 1. House Account, Multivitamin (MVI), (house supply) give 1 tab daily for supplement. 2. Vitamin C 500mg, (house supply), give 500 mg twice a day for supplement. During a review of Resident 621's Medication Administration Record (MAR, log of all medications given to resident), dated 3/27/2024 to 4/2/02024, the MAR indicated LVN 6 administered multiple crushed medications including non-crushable medications altogether as a mixture four times to Resident 621. The medications and administration times are indicated below: 3/27/2024 5:00 PM - Potassium Chloride ER 10 mEq 1 tablet, Losartan 25 mg 1 tablet, and Pilocarpine 5 mg 1 tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/1/2024 9:00 AM - Potassium Chloride ER 10 mEq 1 tablet, Aspirin 325 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Losartan 25 mg 1 tablet, Hydroxychloroquine 200 mg 2 tablets, Pilocarpine 5 mg 1 tablet, Multivitamin 1 tablet, and Vitamin C 500 mg 1 tablet. 4/1/2024 5:00 PM - Potassium Chloride ER 10 mEq 1 tablet, Losartan 25 mg 1 tablet, Pilocarpine 5 mg 1 tablet, and Vitamin C 500 mg 1 tablet. 4/2/2024 9:00 AM- Aspirin 325 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Multivitamin 1 tablet, Losartan 25 mg 1 tablet, Pilocarpine 5 mg 1 tablet, and Vitamin C 500 mg 1 tablet. During an interview on 4/2/2024 at 10:15 AM with LVN 6, LVN 6 stated she did not realize that Resident 621's medication card for Potassium Chloride ER tablets and Hydroxychloroquine indicated Do not chew or crush. LVN 6 stated, .[Resident 621] needs potassium because her potassium levels must be low. LVN 6 stated if potassium was not given on time, it could lead to heart problems, other health complications, leading to hospitalization and potential risk for resident 621's life. LVN 6 stated Resident 621 had a history of stroke (loss of blood flow to part of the brain, which damages brain tissue) and was having hard time swallowing meds. LVN 6 stated crushing non-crushable medications could irritate Resident 621's throat upon administration. LVN 6 stated there was an in-service education about medication administration during the previous week, which licensed nurses were instructed to check administration instructions on medication card labels, the MAR, and the orders section. LVN 6 stated she would ask the director of nursing (DON) or registered nurse (RN) for special instructions about medication administration. LVN 6 stated the order for Potassium Chloride ER would need to be changed on the MAR for safe administration. LVN 6 stated she would contact the physician and pharmacy to request an alternative for Resident 621. During an interview on 4/2/2024 at 1:00 PM with LVN 7, LVN 7 stated extended release and enteric coated (coating applied to medication that prevents its dissolution or disintegration in the gastric environment) tablets such as aspirin and potassium chloride should not be crushed. LVN 7 stated he has administered potassium chloride for Resident 621 as a full tablet. LVN 7 stated it was important to crush each medication individually before mixing with applesauce to keep them separate so that it was easy to separate them in case the resident did not want or did not tolerate one of the medications. During an interview on 4/2/2024 at 1:23 PM with LVN 8, LVN 8 stated, The order will state if the medication can be crushed, not to be crushed, or if to be given with applesauce. LVN 8 stated aspirin and potassium chloride for Resident 621 were not to be crushed. LVN 8 stated she gave potassium separately, as the last medication with a full glass of water. LVN 8 stated she would check with the supervisor, admission record, paper record from the hospital, and the medication card bubble packs if there was a question about special medication instructions. LVN 8 stated she gave medications separately to be able to document if a resident was not able to tolerate a medication or spit out a medication. LVN 8 stated mixing medications together could also decrease absorption for certain medications. LVN 8 stated she administered hydroxychloroquine as crushed without realizing it was enteric coated and should not be crushed, which may potentially be damaging to the stomach lining for residents, decrease absorption, and lead to other complications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/3/2024 at 10:05 AM with Resident 621, in Resident 621's room, Resident 621 was observed awake and lying in bed. There was a note observed in Resident 621's room regarding a hearing aid. Resident 621 did not seem to be wearing the hearing aid. Resident 621 was able to respond to some questions by nodding and saying a few selective words such as yes and I don't know. Resident 621 nodded and stated yes for tolerating medications well. During an interview on 4/3/2024 at 10:19 AM with the Director of Nursing (DON), the DON stated nurses were supposed to check the order, electronic medical record, medication card, and the medication bottle to determine whether the medication was enteric coated before crushing. The DON stated there was a list of medications not to be crushed in the medication cart for nurses to reference. The DON stated nurses were instructed to always ask the supervisor if they were not sure about crushing medications or if they did not have the order to crush the medications. The DON stated if enteric coated and extended-release potassium was given as crushed and swallowed, it could cause gastrointestinal (GI, the tract or passageway of the digestive system that leads from the mouth to the anus, including the esophagus, stomach, and intestines) distress, harm the esophageal lining and lead to further health complications. The DON stated when medications that were not supposed to be crushed, were crushed, and given together, they could cause adverse reactions and drug interactions leading to adverse results for residents and altering the delivery of medication and laboratory results. During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines (California Specific), dated 05/16, the P&P indicated, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber. Long-acting or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. Check for specific prescriber order to crush medications if required by state regulations. Crush medications if indicated for this resident only after referring to the Medications Not To Be Crushed List. For products that appear on the Medications Not To Be Crushed List, check with pharmacist regarding a suitable alternative, and request a new order from the prescriber if appropriate. During a review of the facility's P&P titled, Medications Not to be Crushed, dated 07/15, the document included Potassium Chloride tablets with the reason code of 2 indicating time release formulation. 2. During an observation on 4/2/2024 at 8:35 AM, LVN 6 prepared the below medications and confirmed a total of seven medications to be administered by mouth to Resident 621: 1. Clopidogrel 75 MG, 1 tablet daily, Expiration date 3/26/2025, imprint 34 peach round tablet. 2. Hydroxychloroquine 200 MG, Give 2 tablets (400 mg) by mouth every morning for Sjogren's Syndrome, Expiration date 2/2025, imprint ac 54, Do not chew or crush. 3. Losartan 25 MG, 1 tablet two times a day, hold for SBP <110, imprint 45, Expiration date 3/26/25. 4. Pilocarpine 5 MG, 1 tablet three times a day for Sjogren's Syndrome, Expiration date 2/2025, imprint 5 [NAME]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Potassium Chloride ER 10 MEQ, Give 1 tablet by mouth twice daily for supplement, Expiration date 2/2025, imprint M. Do not chew or crush. 6. House Account, Multivitamin, Expiration date 8/2025, red tab, no directions on bottle (house supply). LVN stated 1 tab daily for supplement. 7. Vitamin C 500 MG, Expiration date 10/26, white tab, no directions on bottle (house supply). LVN stated computer indicated 500 MG twice daily for supplement. 8. Lidocaine 4 percent (%) pain relief patch (house supply), Expiration date 8/2026. 9. Prostat (used to provide increased protein) Expiration date June 23, 2024 (not counted as a medication). During a concurrent interview and record review on 4/2/2024 at 12:35 PM with LVN 6, Resident 621's MAR, dated 4/3/2024 was reviewed. The MAR indicated on 4/2/2024, for the 9:00 AM, administration time, Aspirin 325 mg was administered by LVN 6 on 4/2/2024 at 8:46 AM. LVN 6 stated she did not give Aspirin 325 mg to Resident 621 during the medication administration but accidentally marked it as given when it was not given. LVN 6 stated she got confused because of the interruption in medication administration due to the crushing non-crushable medication error. During an interview on 4/0/2024 at 10:19 AM with the DON, the DON stated staff was supposed to review the physician orders and document that medication was given only after administering to the resident because there was a possibility that medication may be refused by the resident. During a review of the facility's P&P titled, Medication Administration General Guidelines (California Specific), dated 5/2016, the P&P indicated if a regularly scheduled medication is withheld, refused or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. During a review of the facility's P&P titled, Nursing Documentation, dated January 2024, the P&P indicated, All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 3. During a review of Resident 10's Admission Record, the admission record indicated the facility admitted Resident 10 on 10/13/2010 with diagnoses that included Type 2 diabetes mellitus (DM, a chronic [long-term] condition, in which a high level of glucose [sugar] is present in the bloodstream) and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). During a review of Resident 10's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 1/9/2024, the MDS indicated Resident 10 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated Resident 10 required supervision from facility staff for activities of daily living (ADLs, tasks of everyday life that include eating, dressing, getting in and out of bed or chair, bathing, and toileting). (continued on next page)

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Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's Physician Order Summary Report, dated 3/28/2024, the Physician orders included an order for Metformin 850 MG with instructions to give one tablet by mouth two times a day related to Type 2 diabetes mellitus without complications, order date 8/13/2022. During a medication pass observation on 4/2/2024 from 8:41 AM to 8:55 AM., with LVN 3 in Nursing Station 2 at Medication Cart 2, LVN 3 prepared and administered Resident 10's medications that included one tablet of Metformin 850 MG. During a medication reconciliation review on 4/2/2024 at 11:46 AM, Resident 10's current physician orders dated 3/26/2024 and MAR for the month of April 2024 was reviewed. Resident 10's MAR indicated the scheduled administration time for the resident's Metformin 850 MG was 7 AM daily. However, LVN 3 was observed administering Resident's Metformin at 8:55 AM on 4/2/2024, almost two hours after the scheduled administration time of 7 AM. During a concurrent interview and record review on 4/3/2024 at 10:16 AM with LVN 3, Resident 10's physician order for Metformin was reviewed, the MAR for 4/2/2024 and the Administration Detail for 4/2/2024 were reviewed. LVN 3 stated Resident 10's Metformin scheduled administration time was 7 AM. LVN 3 stated he should have administered Resident's 10 medication before 8 AM. LVN 3 stated there is no reason why Resident 10 was not administered Metformin within the time frame of an hour before or after scheduled administration time of 7 AM on 4/2/2024. LVN 3 stated he did not document that Resident 10's Metformin was administered late, and he did not notify Resident 10's physician regarding the late medication administration. During an interview on 4/4/2024 at 4:37 PM, with the DON, the DON stated Metformin should be administered with food. The DON stated if Metformin was given two hours late the licensed nurse should call and notify the resident's physician because access to food was not available at that time. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 5/2016, the P&P indicated, Medication administration timing parameters include the following . Medications to be given with meals are to be scheduled for administration at the resident's mealtime .Medications are administered within 60 minutes of scheduled time . 4. During a review of Resident 16's Admission Record, the admission record indicated the facility admitted Resident 16 on 2/6/2007 and readmitted the resident on 12/15/2023 with diagnoses that included schizophrenia and muscle weakness. During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16 cognition was mildly impaired. The MDS indicated Resident 16 was independent with eating and required setup and/or supervision from facility staff for ADLs. During a medication pass observation on 4/2/2024 from 9:01 AM to 9:14 AM, with LVN 10 in Nursing Station 2, Medication Cart 1, LVN 10 prepared Resident 16's medications that included one tablet of Docusate Sodium 100 MG. LVN 10 left Medication Cart 1 and the computer at Nursing Station 2, walked down the hallway, entered Resident 16's room, called the resident by name and administered the prepared medications to the resident that included the Docusate Sodium 100 MG dose. LVN 10 was not observed identifying Resident 16 before medication administration. Resident 16 was observed not wearing an identification band. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's Physician Order Summary Report, dated 3/25/2024, the Physician orders included an order for Docusate 250 MG, with instructions to give one tablet by mouth one time a day for Bowel Management. Hold for loose stool, order date 12/15/2023. During an interview on 4/2/2024 at 12:37 PM with LVN 10, in Nursing Station 2, LVN 10 stated he administered to Resident 16 Docusate Sodium 100 MG that morning, 4/2/2024, with a 9 AM scheduled administration time but should have given Docusate Sodium 250 MG. LVN 10 stated he made a mistake. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 5/2016, the P&P indicated, Medications are administered in accordance with written orders of the prescriber. 5. During a medication pass observation on 4/2/2024 at 9:12 AM with LVN 10, in Nursing Station 2, Medication Cart 1, LVN 10 was observed entering Resident 16's room, called the resident's name, and administered the prepared medications to the resident. LVN 10 was not observed identifying Resident 16 before medication administration by checking for a name band or asking the resident to state her name or reviewing a photo of the resident. During an interview on 4/2/2024 at 11:16 AM with LVN 10, LVN 10 verified that Resident 16 was not wearing an identification band and that he did not use another method to verify the resident's identity before administering Resident 16's scheduled 9 AM medications on 4/2/2024. LVN 10 stated he should have asked Resident 16 to state her name and date of birth. During an interview on 4/4/2024 at 4:33 PM with the DON, the DON stated if the resident was not wearing an identification band, the licensed nurse should ask the resident to state their name. The DON stated it was not sufficient for the licensed nurses to state the resident's name and then administer medication, as that was not an acceptable way to identify the resident. The DON stated the facility's laptop must be with the nurse if the licensed nurse was using the resident's picture in the computer to identify a resident that was in front of them. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 5/2016, the P&P indicated, Residents are identified before medication is administered using at least two resident identifiers. The P&P indicated the resident's room number or physical location is not used as an identifier. The P&P indicated methods of identification may include: 1.Check identification band. 2. Check photograph attached to medical record. 3. Verify resident identification with other nursing care center personnel. 6. During a review of Resident 53's Admission Record, the admission record indicated the facility admitted Resident 53 on 7/29/2019 and readmitted the resident on 6/17/2023 with diagnoses that included gastrostomy tube (G-tube, is a tube inserted through the abdomen that delivers nutrition and/or medication directly to the stomach), dementia (progressive loss of memory), gastroesophageal reflux disease ([GERD] occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), and dysphagia (difficulty swallowing). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's MDS dated [DATE], the MDS indicated Resident 53 cognition was severely impaired. The MDS indicated Resident 53 was dependent upon facility staff for all ADLs. During a review of Resident 53's Physician Order Summary Report, dated 4/2024, the Physician orders indicated the following orders: 1. Carafate Oral Suspension 1 gram (GM, unit of weight) per 10 milliliters (ml, unit of volume), order date 3/8/2024, instructions indicated to give 10 ml enterally two times a day for GI distress (gastric distress, is a group of digestive disorders that are associated with lingering symptoms of constipation, bloating, reflux, nausea, vomiting, diarrhea, abdominal pain, and cramping). 2. Multi-Vite Oral Liquid (Multiple Vitamins w/ Minerals), order date 3/8/2024, instructions indicated to give 5 ml enterally one time a day for Supplement. 3. Vitamin C Oral Liquid 500 MG/5 ml, order date 3/8/2024, instruction indicated to give 5 ml enterally one time a day for Supplement. During a medication pass observation on 4/2/2024 from 9:31 AM to 10:04 AM, with LVN 11, in Station 3, Medication Cart 1, LVN 11 was observed preparing morning medications for Resident 53 that included: 1. Carafate Oral Suspension 1 gm/ 10 ml, LVN 11 poured 10 ml of the medication into a medication cup without shaking the medication. Manufacturer's label on the bottle of Carafate Oral Suspension indicated, Shake well before use. 2. Multi-Vite Oral Liquid, LVN 11 poured 5 ml of the medication into a medication cup without shaking the medication. Manufacturer's label on the bottle of Multi-Vite Oral Liquid indicated, Shake well before use. 3.Vitamin C Oral Liquid 500 MG/ 5 ml, LVN 11 poured 5 ml of the medication into a medication cup without shaking the medication. Manufacturer's label on the bottle of Vitamin C Oral Liquid indicated, Shake well before use. During a concurrent observation and interview on 4/2/2024 at 10:20 AM, with LVN 11, in Station 3, Medication Cart 1, the following was observed: At 10:20 AM, LVN 11 entered Resident 53's room to begin administering the resident's prepared medications via G-tube after performing hand hygiene, checking G-tube placement, and flushing the G-tube, LVN 11 stated she will administer all the liquids first. LVN 11 was asked to administer the rest of the prepared medications before the liquid preparations of Carafate, Multi-Vite, and Vitamin C. At 10:44 AM, LVN 11 stated that she would now give the remaining liquids (Carafate, Multi-Vite, and Vitamin C). LVN 11 was stopped and asked to return to the medication cart with the three liquid preparations. LVN 11 completed a G-tube flush, performed hand hygiene, and returned to the medication cart with the three liquid preparations. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:48 AM, LVN 11 reviewed the manufacturer's labels on the three medication bottles of Carafate, Multi-Vite, and Vitamin C and stated that she did not shake the medication well. LVN 1 stated if the medication was not shaken well, the medication can separate and sit at the bottle of the bottle and the resident would not receive the full dose of the medications. LVN 11 prepared the three medications again for administration to Resident 53. During an interview on 4/4/2024 at 4:27 PM with the DON, the DON stated medications with instructions to shake well, should be shaken well prior to administration to the resident to ensure the correct consistency and strength of the medications was administered. The DON stated the correct dose of medication may not be administered to the resident if not mixed well as required by the manufacturer. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 05/2016, indicated, Medications are administered as prescribed in accordance with manufacturers' specifications . Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. 49130

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 621) were free from significant medication errors when Resident 621 received Potassium Chloride ER ([ER- Extended Release] a medication used to prevent or treat low potassium levels in the body) crushed and administered as a mixture with other medications, which was not in accordance with the manufacturer's specifications, and the facility's Policy & Procedure (P&P) titled, Medication Administration-General Guidelines, dated 5/2016 and/or as indicated on the form titled, Medications Not To Be Crushed, list dated 7/2015. These failures resulted in Resident 621 receiving non-crushable Potassium Chloride ER with other medications as crushed and administered as a mixture with the potential to result in drug incompatibilities, adverse reactions leading to changes in potassium levels, irritation, or ulceration to the gastrointestinal ([GI] organ system in human body that includes mouth, throat, esophagus, stomach, small intestine, large intestine, rectum, and anus) tract, hospitalization , or death. Findings: During a review of Resident 621's Admission Record, the admission record indicated Resident 621 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease without heart failure and dysphagia (difficulty swallowing), and oropharyngeal (the middle part of the throat, behind the mouth) phase. During a review of Resident 621's Order Summary Report (a document containing a summary of all active physician orders), dated 3/27/2024, the order summary report indicated, Resident is NOT capable of giving informed consent and/or not able to participate in treatment plan. Resident's legal guardian or appointed representative has been made aware of the resident's medical condition. During a review of Resident 621's Order Summary Report, dated 3/27/2024, the order summary report indicated following list of medications: 1. Potassium Chloride ER Oral Tablet Extended Release 10 milliequivalents (MEQ- a unit of measurement), give 1 tablet by mouth two times a day for supplement, order date 3/26/2024. 2. Losartan potassium Oral Tablet 25 milligram (MG- a unit of measurement), give 1 tablet by mouth two times a day for hypertension (HTN - when the pressure in blood vessels is too high), Hold for systolic blood pressure (SBP - pressure in arteries when heart beats) less than (<) 110, order date 3/26/2024. 3. Clopidogrel Bisulfate Oral Tablet 75 MG, give 1 tablet by mouth one time a day for cerebral vascular accident (CVA- a medical condition with problem in blood flow to brain cells) prophylaxis (prevention), order date 3/26/2024. 4. Hydroxychloroquine Sulfate Oral Tablet 200 MG, give 2 tablets by mouth in the morning for Sjogren's syndrome (a medical condition with symptoms of dry eyes and a dry mouth) 2 tabs = 400 mg, order date 3/26/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Pilocarpine Hydrochloride (HCL) Oral Tablet 5 MG, give 1 tablet by mouth three times a day for Sjogren's Syndrome (a disorder of the immune system), order date 3/26/2024. 6. Aspirin Oral Tablet 325 MG, give 1 tablet by mouth in the morning for CVA Prophylaxis, order date 3/26/2024. During an observation on 4/02/2024 at 8:35 AM, Licensed Vocational Nurse (LVN) 6 crushed seven different medications including Potassium Chloride ER tablets for a total of eight pills altogether with the intent to administer as a mixture with applesauce for Resident 621. Medication cards for Potassium Chloride ER and Hydroxychloroquine tablets indicated Do not Chew or Crush. LVN 6 was stopped by the surveyor at bedside from her intent to administer the crushed mixture of multiple medications including those on Do not crush list to Resident 621. During a review of Resident 621's Medication Administration Record (MAR - log of all medications given to resident), dated 3/27/2024 to 4/2/02024, the MAR indicated LVN 6 administered Potassium Chloride ER tablets as crushed along with other medications altogether as a mixture four times for Resident 621. The medications and administration times are indicated below: 3/27/2024 5:00 PM - Potassium Chloride ER 10 mEq 1 tablet, Losartan 25 mg 1 tablet, Pilocarpine 5 mg 1 tablet. 4/1/2024 9:00 AM - Potassium Chloride ER 10 mEq 1 tablet, Aspirin 325 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Losartan 25 mg 1 tablet, Hydroxychloroquine 200 mg 2 tablets, Pilocarpine 5 mg 1 tablet, Multivitamin 1 tablet, Vitamin C 500 mg 1 tablet. 4/1/2024 5:00 PM - Potassium Chloride ER 10 mEq 1 tablet, Losartan 25 mg 1 tablet, Pilocarpine 5 mg 1 tablet, Vitamin C 500 mg 1 tablet. 4/2/2024 9:00 AM - Aspirin 325 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Multivitamin 1 tablet, Losartan 25 mg 1 tablet, Pilocarpine 5 mg 1 tablet, Vitamin C 500 mg 1 tablet. During a review of Resident 621's care plan titled, Dysphagia, date initiated 3/27/2024, the care plan indicated under goals, Pt (patient) will tolerate LRD (Laryngeal Response Duration) without any overt s/s of aspiration or dysphagia and maintain adequate nutrition/hydration. A further review of the care plan interventions indicated speech therapy (ST) to analyze oral pharyngeal (throat) function safe swallow precautions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2024 at 10:15 AM with LVN 6, LVN 6 stated she did not realize that Resident 621's medication card for Potassium Chloride ER tablets indicated Do not chew or crush. LVN 6 stated, Resident 621 is given potassium tablet because her potassium levels must be low. LVN 6 stated if potassium was not given on time, it could lead to heart problems, other health complications, leading to hospitalization and potentially risking Resident 621 her life. LVN 6 stated Resident 621 had a history of stroke and was having a hard time swallowing meds. LVN 6 stated crushing non-crushable medications could irritate Resident 621's throat upon administration. LVN 6 stated there was an in-service education about medication administration during the previous week, where staff were instructed to check the administration instructions on the medication card labels, the MAR and the orders section. LVN 6 stated she would ask the Director of Nursing (DON) or Registered Nurse (RN) for special instructions about medication administration. LVN 6 stated the order for Potassium Chloride ER would need to be changed on the MAR for safe administration. LVN 6 stated she would contact the physician and pharmacy to request an alternative for Resident 621. During an interview on 4/2/2024 at 1:00 PM with LVN 7, LVN 7 stated enteric coated (barrier applied to oral medication that prevents its dissolution or disintegration in the gastric environment) and extended-release tablets such as Aspirin and Potassium Chloride should not be crushed. LVN 7 stated he has been administering Potassium Chloride ER for Resident 621 as a full tablet. During an interview on 4/2/2024 at 1:23 PM with LVN 8, LVN 8 stated, the order will state if the medication can be crushed, not to be crushed, or if to be given with applesauce. LVN 8 stated Aspirin and Potassium Chloride for Resident 621 were not to be crushed. LVN 8 stated she gave potassium separately, as the last medication with a full glass of water. LVN 8 stated she would check with the supervisor, admission record, paper record from the hospital, and medication card bubble packs if there was a question about special medication instructions. During a concurrent observation and interview on 4/3/2024 at 10:05 AM with Resident 621, in Resident 621's room, Resident 621 was observed awake and lying in bed. There was a note in Resident 621's room regarding a hearing aid. Resident 621 did not appear to be wearing the hearing aid. Resident 621 was able to respond to some questions by nodding and saying a few selective words such as yes and I don't know. Resident 621 nodded and stated yes when asked regarding tolerating medications well. During an interview on 4/3/2024 at 10:19 AM with the Director of Nursing (DON), the DON stated nurses were supposed to check the order, electronic medical record, medication card, and medication bottle if a medication was enteric coated before crushing meds. The DON stated there was a list of medications not to be crushed in the medication cart for nurses to reference. The DON stated nurses were instructed to always ask the supervisor if not sure about crushing medications or if they do not have the order to crush the medications. The DON stated if enteric coated and extended-release potassium was given as crushed and swallowed, it could cause GI distress, harm the esophageal lining and lead to further health complications. The DON stated when medications that were not supposed to be crushed, were crushed and given together, they could cause adverse reactions and drug interactions leading to adverse results for residents and altering the delivery of medication and laboratory results. During a review of the facility's document titled, Medications Not to be Crushed, dated 7/2015, the document indicated Potassium Chloride tablets was listed with the reason code of 2 which indicated time release formulation as the reason. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines (California Specific), dated 5/2016, the P&P indicated, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber. Long-acting or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. Check for specific prescriber order to crush medications if required by state regulations. Crush medications if indicated for this resident only after referring to the Medications Not To Be Crushed List. For products that appear on the Medications Not To Be Crushed List, check with pharmacist regarding a suitable alternative, and request a new order from the prescriber if appropriate.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38740 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved texture and appearance for 23 of 23 residents receiving a pureed diet (a regular diet that has been designed for residents who have difficulty chewing and or swallowing). The texture of the pureed diet was lumpy and not smooth with large pieces of pasta present requiring chewing before swallowing. This deficient practice had the potential to result in meal dissatisfaction, decreased food intake, risk for unplanned weight loss, and placed al 23 residents receiving a pureed diet at risk for choking. Findings: During an initial facility tour on 4/1/2024 at 8:30 AM, complaints about the flavor of the food was identified. During a concurrent observation and interview on 4/2/2024 at 11:30 AM, with Cook 1, in the kitchen, Cook 1 was observed taking the temperatures of the lunch meal items on the steam table. Cook 1 stated the lunch on 4/2/2024 included lasagna, Italian green beans, and garlic bread. Cook 1 stated a portion of the regular lasagna was taken and pureed to serve for residents receiving the pureed diet. Cook 1 stated the blender was used to puree the lasagna with some broth. During an observation of the lunch tray line service at 11:40 AM, the pureed lasagna was observed dry and not smooth. During the serving of the pureed lasagna, observed pieces of pasta on the plate. During the test tray on 4/2/2024 at 12:27 PM, the pureed lasagna was thick with a lumpy texture. The test tray had some chunky pieces that required chewing and moving around in the mouth prior to swallowing. During a subsequent interview with the Dietary Supervisor (DS), the DS stated the pureed lasagna did not look smooth. The DS stated the consistency should be smooth to swallow. The DS stated the food should stay in the blender longer for a smoother texture. During a concurrent observation and interview on 4/2/2024 at 3:00 PM, with the Registered Dietitian (RD, a health professional who has special training in diet and nutrition), the RD stated pureed products should be smooth with no lumps. The RD observed the pureed lasagna and stated the large pieces present was not acceptable for a pureed diet. The RD stated the big chunks of pasta may have presented a choking risk for residents with swallowing difficulties. During an interview on 4/2/2024 at 3:45 PM, with the RD, the RD stated she verified with the facility's speech therapist (ST, individuals who assess speech, language, cognitive-communication, and oral/feeding/swallowing skills) that pureed products should not require chewing before swallowing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility menu tilted, Pureed Starch (Rice, Pasta, Potatoes), the menu indicated puree on low speed to a paste consistency before adding any liquid. Then gradually add warm milk. Puree should reach a consistency slightly softer than whipped topping. Add stabilizer to increase the density of the pureed food if needed. During a review of the facility policy and procedure (P&P) titled, Regular Pureed Diet, dated 2015, the P&P indicated, The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. During a review of the facility P&P titled, Menu Planning, dated 2023, the P&P indicated, Menus are planned to meet nutritional needs of residents in accordance with established national guidelines physicians' orders. Menus are planned to consider texture. Menus are written for regular and therapeutic diets in compliance with the diet manual.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure tortillas served during lunch time were served in accordance with a physician order for mechanical soft diet (a type of texture-modified diet for people who have difficulty chewing and swallowing) for one of three sampled residents (Resident 81). This failure had the potential to result in Resident 81 being unable to properly chew the tortilla that could result in Resident 81 choking. Findings: During a review of Resident 81's Admission Record (Face Sheet), the Admission Record indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by chemical imbalances in the blood), type 2 diabetes mellitus (a condition that results in too much sugar circulating in the blood), and chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow). During a review of Resident 81's Minimum Data Set (MDS, a standardized screening and assessment tool), dated 2/14/2024, the MDS indicated Resident 81 was able to understand and be understood by others. The MDS indicated Resident 81's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 81 had missing teeth and was on a mechanically altered diet (require change in texture of food or liquids). During a review of Resident 81's Order Summary Report, dated 2/11/2024, the Order Summary Report indicated to provide Resident 81 with a no added salt (NAS), controlled carbohydrate diet (same amount of carbohydrates every day), mechanical soft texture, and thin liquid consistency. During an interview on 4/1/2024 at 10:52 a.m., with Resident 81, Resident 81 stated she did not have any upper teeth and sometimes it was difficult for her to chew. Resident 81 stated sometimes she was served food that was difficult to chew, and she would not eat. During a concurrent observation and interview on 4/1/2024 at 12:45 p.m., with Resident 81, in Resident 81's room, Resident 81's lunch was brought to her room. Resident 81's lunch consisted of two tacos, lettuce, and vegetables. Resident 81 ate the filling of the taco. Resident 81 stated if the tortilla was soft, she would eat the whole taco, but sometimes the tortilla was difficult for her to chew, and she would only eat the filling. During a concurrent observation and interview on 4/2/2024 at 12:15 p.m., with Resident 81, in Resident 81's room, Resident 81 had finished eating her lunch. Resident 81 had two tortillas and lettuce left on her plate. Resident 81 stated the tortillas were difficult to chew so she only ate the filling in the tacos. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/3/2024 at 12:48 p.m., with Resident 81, in Resident 81's room, Resident 81 was observed eating her lunch which consisted of two tacos, lettuce, vegetables, and fruit. Resident 81 had one taco on her plate. Resident 81 stated she was able to eat the first taco but did not eat the tortilla on the second taco because it was too hard. During an interview on 4/4/2024 at 9:30 a.m., with the Dietary Supervisor (DS), the DS stated Resident 81's tacos were prepared on the flat grill with some butter so it would not get too hard. The DS stated Resident 81 was on a mechanical soft diet which meant the food served to her had to be soft so it could be chewed easily. The DS stated the preparation of the tortilla could made the tortilla harder after it was sent out of the kitchen and on Resident 81's plate over time which could make it difficult for Resident 81 to eat. The DS stated if Resident 81 was unable to chew the tortilla properly, she was at risk for choking. During an interview on 4/4/2024 at 10:51 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated a mechanical soft diet was ordered for residents who have difficulty swallowing or difficulty chewing. LVN 2 stated the mechanical soft diet was utilized to prevent choking and aspiration (when something enters the airways or lungs by accident). LVN 2 stated following the mechanical soft diet was important to ensure the resident consumed all the food and necessary calories set out by the dietician. LVN 2 stated if a resident 81 was served any food item that was too hard for her to chew, that placed her at risk of choking. During an interview on 4/4/2024 at 11:04 a.m., with Registered Nurse (RN) 3, RN 3 stated a resident would be on a mechanical soft diet if they could not tolerate a regular diet or texture. RN 3 stated compared to a resident on a regular diet, a resident on a mechanical soft diet may have difficulty with swallowing or chewing. RN 3 stated Resident 81 had missing teeth which caused her to have inadequate chewing compared to someone who had teeth. RN 3 stated serving Resident 81 food that was difficult to chew put her at risk of choking and aspiration. During an interview on 4/4/2024 at 4 p.m., with the Director of Nursing (DON), the DON stated a mechanical soft diet was a step down from a regular diet, where the food was softer for the resident to easily chew and swallow. The DON stated the food served to the residents should be soft enough to chew without difficulty and be able to break down easily. The DON stated if Resident 81 was unable to chew her food served to her, that was an issue because she would not be able to eat the food if it was too hard. The DON stated this put Resident 81 at risk for damage to her gums and at risk for aspiration. During a review of the facility's policy and procedure (P&P) titled, Regular Mechanical Soft Diet, dated 2015, the P&P indicated, The Mechanical Soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified in texture to a soft, chopped, or ground consistency. Soft tortillas were allowed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38740 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1. Six plastic bags of packed lunch with meat sandwiches for residents were stored in the refrigerator with use by dates of 3/27/2024, 3/30/2024, and 3/31/2024, exceeding the storage period for previously prepared sandwiches. There was one medium size container of tomato sauce with a use by date of 3/26/2024, and one medium size container of cooked green beans with a use by date of 3/28/2024, stored in the walk-in refrigerator exceeding use by date mark. There were four ham and cheese sandwiches stored in walk in refrigerator with no date. One container of a liquid egg carton with an open date of 3/27/2024 and manufactures instruction to use within 3 days stored in the walk-in refrigerator exceeding manufactures use by date. One large bowl of previously prepared whipped cream stored in the walk-in refrigerator uncovered and open to the refrigerator environment. Ready to eat deli meats including ham and roasted turkey were stored in a container that was dirty with juices and small pieces from the deli meats. 2. Dry storage area was not maintained in a clean manner. There was food debris on top of the bulk food containers. The bin liner inside the bin holding flour was torn and flour spilled inside the bin. 3. Previously cooked ground beef with preparation date of 3/27/2024 and use by date of 3/29/2024 was used to prepare lunch on 4/1/2024. The ground beef was not monitored for safe cool down process (hot food cooled down within a certain time frame to prevent harmful bacterial growth). These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 166 out of 171 residents who received food from kitchen. Findings: 1. During an observation on 4/1/2024 at 8:30 AM, in the kitchen, there were six packed lunch bags with ham sandwiches stored in the walk-in refrigerator. One bag had a use by date of 3/27/2024, two bags had use by date of 3/30/2024, and three bags had use by date of 3/31/2024, stored in the walk-in refrigerator. During the same observation, there was one medium size container with cooked green beans with a use by date of 3/28/2024 and one medium size container of tomato sauce with a use by date of 3/26/2024 stored in the walk-in refrigerator. During a concurrent observation and interview with the Dietary Supervisor (DS) on 4/1/2024 at 8:30 AM, the DS stated the packed lunch sandwiches were prepared for residents leaving the facility for dialysis appointments. The DS stated the sandwiches were prepared a day before the appointment. The DS stated the sandwiches were old and needed to be discarded. The DS stated the cooked beans and tomato sauce should be discarded because the items exceeded the use by date mark. The DS stated all items should be used within 3 days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation in the walk-in refrigerator there were four ham and cheese sandwiches with no date stored on the top shelf of the walk-in refrigerator. The DS stated she did not know when the sandwiches were prepared. The DS stated the dates were necessary to know when food was prepared so staff knew when to discard the items before the expiration date. During a concurrent observation, interview, and record review, on 4/1/2024 at 8:45 AM, in the kitchen, with the DS, the manufacturer's instructions printed on the liquid egg carton was reviewed. One carton of liquid eggs with an open date of 3/27/2024 was stored in the walk-in refrigerator. The manufacturer's instructions indicated to use the liquid eggs within 3 days after its open date. The DS stated the liquid eggs were opened on 4/1/2024 and the date represented when the item was received from the vendor and not the open date. The DS stated the staff made a mistake in writing the date. During a concurrent observation and interview on 4/1/2024 at 8:50 AM, with the DS, in the walk-in refrigerator, there was one large bowl of whipped cream stored in the walk-in refrigerator uncovered on the top shelf and under the refrigerator fan, open to the refrigerator environment. The DS stated everything should be covered in the refrigerator to prevent cross contamination of food. During a concurrent observation and interview on 4/1/2024 at 8:55 AM, with the DS, in the walk in refrigerator, there was one large container with ready to eat smoked ham deli meat and another container with smoked turkey deli meat. The containers had juices present with pieces of deli meat and other food debris observed. The DS stated the containers were not clean. The DS removed the containers from the walk in refrigerator. The DS stated the containers that held food had to be clean and washed on a daily basis to prevent cross contamination of food. During an interview on 4/2/2024 at 11:45 AM, with the Assistant Dietary Supervisor (ADS), the ADS stated all food should be labeled, dated, and covered during storage for infection control, food safety, and to prevent cross contamination of food and to provide good quality and safe food to the residents. During a review of the facility policy and procedure (P&P) titled, Procedure for refrigerated storage, dated 2023, the P&P indicated, Refrigeration equipment should be routinely cleaned. Leftovers will be covered, labeled, and dated. A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. 2. During a concurrent observation and interview on 4/1/2024 at 9:00 AM, with the DS, in the dry storge area, there were white particles of food debris on top of the plastic containers. The cover of a bulk food container storing barley was observed with food particles and a sticky substance. The bulk food bin was observed lined with a plastic liner storing flour. The liner inside the bin was torn and the flour was spilled inside the large bin. There were rusted metal parts observed inside the bin. The DS stated the dry food storage area should always be clean to prevent pests and the liners storing bulk food such as flour should be intact. The DS discarded the flour. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Storage of Food and Supplies, dated 2023, indicated, storeroom should be always .clean. Dry bulk food should be stored in seamless metal or plastic containers with tight covers or in bins which are easily sanitized . if using plastic bags for dry bulk food storage, food grade bags must be used. 3. During an observation on 4/1/2024 at 9:30 AM, in the kitchen, there was cooked ground beef in a large deep pan that was stored on a cart in the cook's food preparation area. The large pan with the ground beef was warm to the touch. The pan was covered with plastic wrap dated 3/27/2024 and a use by date of 3/29/2024. During a concurrent observation and interview on 4/1/2024 at 9:30 AM, with Dietary Aide (DA) 1 and the DS, DA 1 stated the ground beef was to be used for lunch (on 4/1/2024) for the mechanical soft diet (type of texture-modified diet for people who have difficulty chewing and swallowing) trays. DA 1 stated he did not cook the ground beef. DA 1 stated the ground beef was previously cooked and stored in the refrigerator. DA 1 stated he took the ground beef out of the refrigerator and warmed it in the steamer. During a concurrent interview and record review on 4/1/2024 at 9:40 AM, with the DS, the cool down log was reviewed. The cooking and the cooling of the ground beef was not documented on 3/27/2024. During an interview on 4/1/2024 at 9:45 AM, with Cook 1 and the DS, Cook 1 stated the ground beef was previously cooked and stored in the freezer. Cook 1 stated there were two large pans of ground beef in the freezer that was cooked on 3/30/2024 and documented on the cooling log. Cook 1 stated she did not know who cooked the ground beef on 3/27/2024. Cook 1 stated she did not look at the dates and made a mistake when she pulled out the ground beef dated 3/27/2024. Cook 1 stated the ground beef cooked on 3/27/2024 was not safe because she did not know if it was cooled and stored in a safe way. The DS stated she would discard the ground beef cooked on 3/27/2024. During a review of the facility P&P titled, Procedure for refrigerated storage, dated 2023, the P&P indicated, Hot foods which are to be refrigerated should be placed in shallow pans to permit rapid cooling. A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility did not implement infection practices as outlined in the facility's infection control program when the facility did not perform the following: 1. Implement Enhanced Barrier Precautions ([EBP]-the use of gown and gloves for specific care activities that involve a high chance of the spread of infection), as mandated, to limit the spread of infections. 2. Ensure the Treatment Nurse wore proper personal protective equipment ([PPE] -a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) during Resident 88's wound treatment. 3. Ensure certified staff used PPE when providing wound treatment for Resident 129. 4. Follow their own policy and procedures (P&Ps) titled, Hand Washing/Hand Hygiene, dated 1/2023, to ensure licensed nurses wash or sanitized hands before and after taking the blood pressure ([BP], a measurement of the force exerted against the walls of the arteries as the heart pumps blood to the body) and measuring oxygen saturation (amount of oxygen in the blood) for one of five residents (Resident 16) observed during medication pass observation. These failures had the potential to result in the spread of contaminants, disease, and infection to all residents and staff within the facility. Findings: 1. During a review of a memorandum authored by the Department of Health and Human Services: Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, titled, Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 3/20/2024, the memorandum indicated that facilities were to implement EBP by 4/1/2024. During a review of the In-Service Sign in Sheet for Enhanced Standard Precautions (ESP) and the ESP Lesson Plan, dated 3/28/2024, indicated that Registered Nurse (RN) 2 in-serviced the facility staff on the definition of ESP, the type of residents that were considered for ESP, and how to implement the ESP. The lesson plan indicated that facility staff were to don a gown and gloves when performing six of the following tasks: 1. Morning and Evening care. 2. Toileting and changing incontinence briefs. 3. Caring for devices and giving medical treatments. 4. Wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Providing mobility assistance. 6. Cleaning and disinfecting the environment. During a concurrent interview and record review, on 4/3/2024, at 11:34 a.m., with RN 2, the In-Service Sign in Sheet for ESP and the ESP Lesson Plan, dated 8/22/2023, was reviewed. The sign in sheet indicated that facility staff were in-serviced on the definition of ESP, the type of residents that were considered for ESP, and how to implement the ESP. RN 2 stated that the facility had knowledge of ESP in 2023 and of the mandatory implementation of EBP on 3/28/2024 and was not able implement the practice because the facility had planned to allot more time to cohort residents that needed to be on EBP. During an interview, on 4/3/2024, at 12:34 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated that there was a potential for the development of more infections amongst all the residents in the facility due to the lack of the implementation of EBP. During an interview, on 4/4/2024, at 1:18 p.m., with the Director of Nursing (DON), the DON stated that the implementation of EBP could help mitigate the spread and prevention of in-house acquired infections within the facility. During a review of the facility's Infection Control Preventionist Job Description, the job description indicated that the IPN was to facilitate compliance and stay current with regulatory and accreditation standards for infection control. 47679 2. During a review of Resident 88's Admission Record (Face Sheet), the Admission Record indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included cellulitis of the left lower limb (skin infection that spreads rapidly), type 2 diabetes mellitus (a condition that results in too much sugar circulating in the blood), and cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area). During a review of Resident 88's Minimum Data Set (MDS, a standardized screening and assessment tool), dated 1/18/2024, the MDS indicated Resident 88 was able to make himself understood and understood others. The MDS indicated Resident 88's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 88 required moderate assistance with personal hygiene where he provided less than half the effort. During a review of Resident 88's History and Physical (H&P), dated 1/5/2024, the H&P indicated Resident 88 had the capacity to understand and make decisions. During a review of Resident 88's Order Summary Report, dated 3/29/2024, the Order Summary Report indicated: a. For Resident 88's infected left lower leg wound, cleanse the skin and soft tissue with the skin and wound cleanser, pat dry, apply Flagyl (medication used to treat an infection) ointment, cover with xeroform gauze (a type of wound dressing), and wrap with dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. For Resident 88's infected left lower leg wound, cleanse the skin and soft tissue with the skin and wound cleanser, pat dry, apply Gentamycin (medication used to treat an infection) ointment, cover with xeroform gauze (a type of wound dressing), and wrap with dressing. During an observation on 4/4/2024 at 9:56 a.m., in Resident 88's room, Treatment Nurse (TN) 1 sanitized the bedside table, placed her supplies onto the table, washed her hands with soap and water, and applied gloves prior to beginning Resident 88's wound treatment. TN 1 did not wear a disposable gown prior to entering Resident 88's room. TN 1 approached Resident 88 and he provided his consent for TN 1 to proceed with the treatment. TN 1 wore gloves when she removed Resident 88's dressing over the wound on his left leg. Resident 88's wound bed was pink and had well-defined edges. TN 1 removed her gloves, washed her hands with soap and water, and applied new gloves after each step of the treatment. TN 1 cleansed, patted dry, applied the medicated ointment, and applied the gauze and dressings to Resident 88's wound. TN 1 cleaned her work area, disposed of the old dressings and supplies, and sanitized the bedside table. Throughout Resident 88's wound treatment, TN 1 disposed of used gloves and applied new gloves. TN 1 did not wear a disposable gown at any time during Resident 88's wound treatment. 48343 3. During a review of Resident 129's Admission Record (Face Sheet), the Face Sheet indicated Resident 129 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection (UTI, infection of the bladder), pressure ulcer ([PU], injury to skin and underlying tissue resulting from prolonged pressure on the skin or bony prominences) of the sacral (bone in the lower spine that forms part of the pelvis) Stage IV (full thickness loss with exposed bone), hypertension (high blood pressure), and muscle weakness (a lack of muscle strength). During a review of Resident 129's MDS, dated [DATE], the MDS indicated Resident 129 was able to understand and be understood by others. The MDS indicated Resident 129 required maximum assistance from staff for toileting and personal hygiene. The MDS indicated Resident 129 had one Stage IV PU present upon admission to the facility. During a review of Resident 129's Order Summary Report, dated 3/2/2024, the order summary report indicated sacrum (sacral) wound cleanse with normal saline (NS), pat dry, apply Santyl (medicine to remove dead tissue from the wound so wound can start to heal) to wound bed (open area of a wound), light wick (a strip placed into wound bed) with calcium alginate (substance of being dissolved) and calcium alginate applied over the wound bed and cover with foam dressing (material to absorb fluid that comes from the wound) every day shift. During an observation on 4/1/2024 at 12:30 AM, in front of Resident 129's room, there was no Enhanced Barrier Precaution sign posted, and there was no PPE available upon entrance to Resident 129's room. During a concurrent observation and interview on 4/1/2024 at 12:32 AM, in Resident 129's room. Resident 129 was observed lying in bed on her back and watching television. Resident 129 stated the licensed nurse came into the room every day to take care of the resident's wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/3/2024 at 8:45 AM, in front of Resident 129's room there was no Enhanced Barrier Precaution sign posted, and there was no PPE available upon entrance to Resident 129's room. During a concurrent observation and interview on 4/3/2024 at 9:05 AM, in Resident 129's room with TN 2, observed TN 2 prepare wound treatment supplies (medical items used for the treatment), explain the procedure to Resident 129, wash their hands with soap and water, and apply gloves. TN 2 did not wear a PPE gown. TN 2 performed wound treatment as ordered. TN 2 stated the facility did not use PPE gowns if a resident had no active infection, or history of infection. TN 2 stated she wore PPE gowns if a resident's wound had secretion (substance discharge), or there was a potential for splashing (wet or soiled particles). TN 2 stated during high contact resident care certified facility staff must use a PPE gown. TN 2 stated Resident 129's wound treatment was considered high contact resident care, and she should be wearing a PPE gown during wound treatment. TN 2 stated a PPE gown was important for protecting residents and staff at the facility for infection and preventing infection from spreading. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precaution, dated 3/2024, the P&P indicated it was the policy of the facility to implement enhanced barrier precaution for the prevention of transmission of multidrug-resistant organisms. The P&P indicated Enhanced barrier precautions refers to the use of gown and gloves for use during high contact resident care activities, for residents with wounds. The P&P indicated the following: 1. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and high contact resident care activities that require the use of gown and gloves. 2. High contact resident care activities include: a. Dressing (protect the wound from environment). b. Wound care, any skin opening requiring a dressing. 31333 4. During a review of Resident 16's Admission Record, the admission record indicated Resident 16 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a serious mental disorder in which people interpret reality abnormally), personal history of COVID-19 (a disease caused by a virus, that can be contagious and spread quickly). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16's cognition was mildly impaired. The MDS indicated Resident 16 was independent with eating and required setup and/or supervision from facility staff for activities of daily living (ADLs, tasks of everyday life that include dressing, getting in and out of bed or chair, bathing, and toileting). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555128	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downey Community Health Center	8425 Iowa Street Downey, CA 90241

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and medication pass observation on 4/2/2024 between 9:01 AM to 9:14 AM, with LVN 10 in Nursing Station 2, Medcart 1, LVN 10 after touching the medication cart, drawers, stated he prepared four medications for Resident 16. LVN 10 entered the resident's room without washing his hands with soap and water or using an alcohol-based hand sanitizer, called the resident by name, then used a wrist BP monitor to check Resident 16's blood pressure and placed and a pulse oximeter (used to measure the oxygen level [oxygen saturation] of the blood) on the resident's right finger. LVN 10 removed the BP monitor and pulse oximeter and completed the medication administration and left the resident's room without washing or sanitizing his hands. During an interview on 4/2/2024 at 11:23 AM, with LVN 10, LVN 10 stated he did not sanitize his hands before entering Resident 16's room to care for the resident. LVN 10 stated he should have sanitized his hands to prevent transmission of disease. During an interview on 4/4/2024 at 4:30 PM with the Director of Nursing (DON), the DON stated nurses must sanitize with alcohol based hand sanitizer or wash their hands when they provide direct resident care, prior to entering the resident's room to administer medication. The DON stated the best practice was to wash their hands or sanitize their hands upon leaving a resident's room. During a review of the facility's P&P titled, Handwashing/ Hand Hygiene, dated 1/2023, the P&P indicated, All staff members will wash their hands before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of nosocomial infection .Employees must wash hands under the following conditions .Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to assess the need for modifications to the call light system for one out of eight sampled residents (Resident 124), who had difficulty activating the call light. This deficient practice had the potential to result in a delay in obtaining necessary care and services. Findings: During a review of Resident 124's Admission Record, the admission record indicated Resident 124 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included respiratory failure (serious condition that makes it difficult to breathe) and blindness to one eye. During a review of Resident 124's History and Physical (H&P) dated 3/1/2024, the H&P indicated Resident 124 did not have the capacity to understand and make decisions. During a review of Resident 124's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/13/2024, the MDS indicated Resident 124's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 124 was dependent on staff for personal hygiene, toileting hygiene, oral hygiene, eating, dressing and for showers. The MDS indicated Resident 124's vision was moderately impaired, and the resident had functional limitation to the upper extremities (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 124 received oxygen therapy and received hospice care (care for the dying or terminally ill). During a review of Resident 124's Abnormal Involuntary Movement Scale (AIMS) form, dated 3/29/2024, the AIMS form indicated Resident 124 had left sided weakness. During an observation on 4/2/2024 at 9:38 a.m., in Resident 124's room, Resident 124 was observed attempting but unable to activate the call light. During an interview on 4/2/2024 at 9:40 a.m. with Resident 124, in Resident 124's room, Resident 124 stated she was unable to push call light with her right hand because she was too weak and unable to make her fingers push the call light button. Resident 124 stated she could not use her left hand due to a stroke (unexpected electrical activity of the brain causing injury to the brain). Resident 124 stated that she attempted to push call light but it was very hard because her fingers hurt and she could not move them. Resident 124 stated she would prefer another call light system that would be easier to use and that would accommodate her inability to easily move her fingers. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/2/2024 at 9:46 a.m., with Certified Nursing Assistant (CNA) 3, in Resident 124's room, CNA 3 placed the call light in Resident 124's hand. CNA 3 stated it was acceptable to place the call in Resident 124's left hand even though Resident 124 was not able to move that hand. CNA 3 asked Resident 124 to push her call light. Resident 124 attempted to push the call light but was unable to push the button. CNA 3 stated she was aware Resident 124 was not able to push call light button but did not do anything about it. CNA 3 stated Resident 124 needed another call light system, a pad with a sensor where Resident 124 did not have to push anything. CNA 3 stated she should have assessed that before but did not. CNA 3 stated it was important for all residents to have a call light in order to be able to communicate their needs. During an interview on 4/3/2024 at 3:21 p.m. with the Director of Staff Development (DSD), the DSD stated all residents must have a call light system they could use to communicate their needs. The DSD stated for residents that were unable to push the call light and have weakness on their extremities and hands, it would be appropriate for them to have a touch pad call light system. The DSD stated the touch pad call light system would be more appropriate in accommodating Resident 124's needs. The DSD stated it was important to provide a call light system that a resident could use to help with their needs, during an emergency, and to assist the resident instead of having the resident get out of bed and have them fall. During an interview on 4/4/2024 at 4:04 p.m. with the Director of Nursing (DON), the DON stated residents with dexterity limitations and with weakness in the arms and fingers must use a touch pad call light. The DON stated if an inappropriate call light was given to a resident, the resident would not be able to use the call light and they would not be able to call for help. During a review of the facility's Policy and Procedure (P&P) titled, Accommodation of Needs, dated 1/2024, the P&P indicated the facility will provide accommodations to the needs of the resident through simple modifications in the environment that is reasonable. The P&P indicated resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.